

**TRANSMITTAL AND NOTICE OF APPROVAL  
OF STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER

01-08

2. STATE:

**ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:  
July 1, 2001

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐  
AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT

a. FFY 01 \$ 0  
b. FFY 02 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, page 17  
Attachment 4.19-A, page 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-A, page 17  
Attachment 4.19-A, page 18

10. SUBJECT OF AMENDMENT:

**Inpatient Hospital - DRG (Removal of physician attestation)**

11. GOVERNOR'S REVIEW (Check One)

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Not submitted for review by prior  
approval.

12. SIGNATURE OF AGENCY OFFICIAL:

13. TYPED NAME:

**Jackie Garner**

14. TITLE:

**DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

**ILLINOIS DEPARTMENT OF PUBLIC AID  
201 SOUTH GRAND AVENUE, EAST  
SPRINGFIELD, IL. 62763-0001  
ATTENTION: John Rupcich**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 7/11/01

18. DATE APPROVED: 8/21/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME

**Cheryl A. Harris**

22. TITLE: Associate Regional Administrator

23. REMARKS:

Division of Medicaid and Children's Health

**RECEIVED**

**JUL 11 2001**

**DMCH - IL/IN/OH**

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL  
REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT  
(MANG)

09/91 D. Medical Review Requirements: ~~DRG Validation~~

- ~~1. Physician attestation. Beginning with admissions on or after September 1, 1991, for which the discharge occurs on or after December 15, 1991, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record and, except as provided in Section D.2. of this Chapter, the physician must sign the statement. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's dated signature:~~

~~"I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."~~

~~The physician's name must be typed or clearly printed and appear on the same page as the physician's signature.~~

- ~~2. Alternative signature requirement. The attending physician's signature, along with the other information required in Section D.1. of this Chapter, may be provided by electronic means through a hospital data system if the hospital's Title XVIII (Medicare) intermediary has determined that the hospital data system meets the guidelines established by the Health Care Financing Administration, U.S. Department of Health and Human Services, under the Medicare Program.~~

TN # 01-08

APPROVAL DATE \_\_\_\_\_

EFFECTIVE DATE 7-01-01

SUPERCEDES

TN # 93-19

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL  
REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT  
(MANG)

1.3. DRG Validation. The Department or its designee may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

2.4. Sample Reviews.

- a. The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.
- b. Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.

3.5. Revision of Coding. If the diagnostic and procedural information attested to by the physician as stipulated under Section D.5.a. of this Chapter is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding, ~~and the Department shall recalculate the payment on the basis of the revised coding.~~

~~a. If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~

~~b.~~

09/91 E. Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

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APPROVAL DATE \_\_\_\_\_ EFFECTIVE DATE 7-01-01

SUPERCEDES

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